Public Health Legal Preparedness in Indian Country

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American Indian/Alaska Native tribal governments are sovereign entities with inherent authority to create laws and enact health regulations. Laws are an essential tool for ensuring effective public health responses to emerging threats.

To analyze how tribal laws support public health practice in tribal communities, we reviewed tribal legal documentation available through online databases and talked with subject-matter experts in tribal public health law. Of the 70 tribal codes we found, 14 (20%) had no clearly identifiable public health provisions. The public health–related statutes within the remaining codes were rarely well integrated or comprehensive.

Our findings provide an evidence base to help tribal leaders strengthen public health legal foundations in tribal communities. (*Am J Public Health.* 2009; 99:607–614. doi:10.2105/AJPH.2008.146522)

IN AN ERA WHEN PUBLIC health threats are growing in number, severity, and complexity, it is critical to ensure that all levels of government have the capacity to mount effective public health responses. Failure to do so threatens a government's ability to deliver essential public health services to its population. The 10 essential public health services are:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Conduct research for new insights and innovative solutions to health problems.[1]

Laws are an essential tool for improving public health capacity and thus public health outcomes.[2] Effective responses to emerging threats and the attainment of public health goals require that governments and their partner organizations be legally prepared. Public health legal preparedness is defined as a public health system's attainment of specified legal benchmarks or standards that include ensuring the presence of effective legal authority to carry out essential public health services, establishing and sustaining the competencies of public health professionals to apply that authority through laws, providing for coordination of law-based efforts across jurisdictions and sectors, and developing and disseminating information about best practices in public health law.[3]

American Indian/Alaska Native (AIAN) tribal governments are sovereign entities with the authority to enact their own health regulations to protect the health, safety, and welfare of their communities. Jurisdictional authorities in Indian country are complex, however, because the delivery of public health services is often distributed across tribal, county, state, and federal public health systems. The Indian Health Service (IHS) continues to be the primary provider of public health services in some regions, but in other areas, tribal governments are increasingly assuming these responsibilities. Tribal communities are generally not subject to state public health laws, and the extent to which tribal governments have codified public health authority within tribal law is not clear.

Recent instances of successful intergovernmental cooperation in times of crisis were made possible by prior agreements concerning specific public health authorities.[4] Successful collaborations such as these demonstrate the valuable role that intergovernmental agreements and other legal tools play in facilitating effective public health responses. Tribal leaders are aware of the legal gaps in public health authority, and they have begun to explore ways to strengthen the legal foundations of public health within their systems of government. Although their heightened interest in public health law has been catalyzed in part by federal and state emergency preparedness initiatives, it also goes hand in hand with the tenets of tribal self-determination.

The Centers for Disease Control and Prevention (CDC) Tribal Public Health Law Work Group was established in response to tribal requests for greater CDC involvement in this important arena. Recognizing the urgent need for a more thorough understanding of extant tribal public health law, the Tribal Public Health Law Work Group sought to analyze how tribal laws currently support public health practice in tribal communities. To our knowledge, this report is the first published account of such an analysis, the results of which can serve as an evidence base for tribal leaders as they develop strategies to establish stronger legal foundations for public health in their communities.

BACKGROUND

Tribal Populations and Communities in the United States

There are currently 562 federally recognized AIAN tribes located in 34 states.[5] The AIAN population is approximately 4.5 million people and constitutes approximately 1.5% of the total US population. Although a significant number of AIAN people live in rural locations such as reservations, more than 60% of AIAN people now reside in urban settings.[6]

Criteria for tribal membership vary from tribe to tribe, and tribal enrollment ranges from fewer than 200 members to 301 800 members per tribe.[7] Tribal governments' land bases vary from a few acres to tens of thousands of acres. The tribes with the largest populations and land bases tend to be located in the western United States. Some tribal nations exist entirely within a given state, whereas others straddle state borders. Fifteen tribes have international borders with Canada or Mexico, and many more are located within 100 miles of an international boundary; for instance, several Alaska Native villages are in close proximity to Russia.[8] A number of tribal governments are located near major metropolitan areas, but most are situated in relatively isolated rural parts of the country. AIAN lands today represent 2% of original tribal land holdings.[9] Collectively, tribal lands, reservations, and communities are often referred to as "Indian country," and the term is used in that sense herein (in contrast to its more restricted definition when used in the context of federal Indian law).[10]

Although most American Indians/Alaska Natives receive health care and public health services from tribal health programs, the IHS, and urban Indian health centers, an increasing number also have access to health services through private health insurance.[11] Delivery of public health services to AIAN communities is affected by the shifting availability of federal funding, variability in tribal and IHS public health capacity, historically strained relationships between tribes and states, and jurisdictional complexities that blur the lines of public health authority across Indian country.

Tribal Sovereignty and Public Health Authority

The United States has a unique legal and political relationship with AIAN tribes as provided for by the US Constitution, treaties, federal statutes, executive orders and memoranda, US Supreme Court decisions, and other case law.[12–16] The Indian Reorganization Act of 1934, landmark legislation in federal–tribal relations, is part of the foundation for tribal self-government as it exists today.[17,18] In addition, the Indian Self-Determination and Education Assistance Act (Public Law 93-638) and the Indian Health Care Improvement Act were passed in 1975 and 1976, respectively.[19,20] Language in the Self-Determination Act acknowledged that federal domination stifled tribal self-governance and development. Self-determination policies have enabled tribes to administer service programs themselves, shifting direct service provision away from the federal government through a process commonly referred to as "638," in reference to Public Law 93-638. The process complements tribes' sovereign authority to enact their own public health legislation.

As the implementation of self-governance continues, tribal leaders are increasingly acknowledging the need for clearly articulated public health authority and the importance of public health legal preparedness through the enactment of appropriate laws. Tribal laws are created by the appropriate governmental bodies within each tribe, such as tribal councils or tribal legislatures. The authority to implement and enforce these laws rests with various agencies within other branches of tribal governments, such as the judicial and the executive. As is the case with the laws of other governments, tribal laws are often organized into legal codes, many of which are available for public review on the Internet.

METHODS

We reviewed tribal legal documentation available through online databases over an 11-week period in the summer of 2006. We also talked with selected public health and legal professionals who were subject-matter experts in tribal public health law, and we summarized their informal comments and suggestions across 3 broad topical areas: structural characteristics, salience, and challenges.

Our online review focused on legal codification of selected essential public health services and other public health–oriented statutes. Public health has been defined as encompassing 3 core functions—assessment, policy development, and assurance[21]—so our online review targeted the essential services of public health associated with the core functions of assessment and assurance (e.g., monitor health status, diagnose and investigate health problems, and enforce laws and regulations that protect health and ensure safety[1]). In an attempt to identify all health-related provisions in each code we reviewed, we used search terms such as "public health," "disease," "quarantine," "surveillance," "tracking," "tracing," "monitor," and "health."

Our review encompassed relevant English-language Web sites of universities and national organizations. The majority of Web sites linked to the National Tribal Justice Resource Center (NTJRC) and the National Indian Law Library (NILL), and all but 2 tribal legal codes were identified through these links. Both the NTJRC and the NILL contained electronic versions of tribal codes, constitutions, and court opinions. In addition to conducting keyword searches on the NTJRC and NILL databases, we also reviewed each available tribal code in its entirety to help us find all health-related provisions. After we completed the review of available tribal codes, we searched for resources from other Web sites dedicated to tribal law and policy (see appendix A, available as a supplement to the online version of this article at http://ajph.org).

We also searched online for examples of intergovernmental

agreements such as memoranda of agreement or understanding, mutual aid agreements, data-sharing agreements, and model documents or templates. Our review did not include federal Indian law, fiscal relationships between federal or state governments and tribes such as grants or contracts, tribal constitutions, or case law.

RESULTS

Tribes and Tribal Legal Codes

Our online review found legal codes for 70 tribes across 25 states (see appendix A, available online at http://ajph.org). Tribal enrollment data were available for 61 of these tribes. Among those, tribal membership ranged from 50 to 300 000 persons, with the majority of tribal enrollment totals falling between 1000 and 10 000. Average tribal membership was 11 200 persons.

Of the 70 tribal codes available on the Internet, 14 (20%) had no relevant public health provisions. Among the remaining 56 codes, 4 (7%) provided for the establishment of tribal health boards or divisions of health but did not clearly articulate those entities' public health authority. Two (4%) codes created a health care committee or quality assurance board to work in tandem with a tribal health department but did not contain parallel provisions empowering the health department itself. Nineteen (34%) tribal government Web sites showed evidence of health departments or public health programs for which no statutory basis was evident in their respective tribal codes. Only 2 (4%) codes specifically outlined tribal authority to enter into health-related intergovernmental agreements.

Public health statutes in the 56 tribal codes varied in scope, with most focusing on topics such as substance abuse, mental illness, tobacco control, environmental health issues (water quality, solid waste disposal, and housing ordinances), public safety, injury prevention, sanitation, and protection from violence (Table 1).

Ten tribal codes (18%) contained at least 1 law specifically addressing disease control and surveillance authorities such as quarantine, mandatory treatment, contact tracing, compulsory vaccination, notifiable disease reporting, public health surveillance, or outbreak investigations (see the box on the next page). Nine (16%) codes contained a quarantine or isolation provision, 2 of which were adopted from the legal code of the state in which the tribe was located. Six (67%) of the 9 quarantine provisions contained due-process protections.

Seven codes (13%) contained provisions authorizing compulsory vaccination or mandatory treatment of communicable disease. Four codes (7%) criminalized knowingly spreading communicable diseases (e.g., sexually transmitted diseases, tuberculosis). The majority of the quarantine, mandatory treatment, and involuntary confinement provisions contained specific cultural guidance, including references to traditional tribal healers. In such instances, the disease-reporting provisions required traditional healers to report certain illnesses,

TABLE 1—Inventory of Public Health–Related Provisions in 56 American Indian/Alaska Native Legal Codes: 2006

Specific Public Health Provision	Tribal Codes Containing Provision, No. (%)
Environmental health and sanitation (133 provisions)	
Housing	33 (59)
Land use/zoning	20 (36)
Water quality	20 (36)
General/pollution	20 (36)
Solid-waste disposal	15 (27)
Food sanitation	13 (23)
Air quality	5 (9)
Burial/coroner	3 (5)
Hazardous materials	3 (5)
Flood control	1 (2)
Public safety and injury prevention (90 provisions)	
Motor vehicle/traffic	34 (61)
Juvenile curfew	27 (48)
Animal control	18 (32)
Gun control	5 (9)
Fire prevention	4 (7)
Occupational safety	2 (4)
Protection from violence and abuse (73 provisions)	
Child abuse	32 (57)
Domestic/sexual abuse	27 (48)
Elder abuse	9 (16)
Substance abuse, mental illness, and tobacco use (63 provisions)	
Alcohol control	31 (55)
Tobacco control	11 (20)
Involuntary confinement[a]	10 (18)
Drug control	8 (14)
Mental health	3 (5)
Communicable disease control, surveillance, and research (31 provisions)	
Quarantine/isolation	9 (16)
Disease reporting/surveillance	8 (14)
Mandatory treatment/vaccination	7 (13)
Health research	4 (7)
Contact tracing/disease investigation	3 (5)
Other (4 provisions)	
Autopsies	2 (4)
Contraceptives	1 (2)
Fluoridation	1 (2)

[a]For mental illness or drug or alcohol rehabilitation.

American Indian/Alaska Native Tribes With Tribal Statutes That Address Communicable Disease Control, Surveillance, and Research: 2006

Quarantine or isolation provision (n = 9)
- Colorado Indian River Tribes
- Eastern Band of Cherokee
- Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation
- Mississippi Band of Choctaw
- Navajo Nation
- Oglala Sioux
- Red Lake Band of Chippewa
- Tulalip Tribes
- White Mountain Apache

Mandatory treatment or compulsory vaccination (n = 7)
- Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation
- Navajo Nation
- Oglala Sioux
- Poarch Band of Creek Indians
- Red Lake Band of Chippewa
- Tulalip Tribes
- White Mountain Apache

Disease reporting requirement (n = 6)[a]
- Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation
- Eastern Band of Cherokee
- Navajo Nation
- Red Lake Band of Chippewa
- Tulalip Tribes
- White Mountain Apache

Surveillance provision (n = 2)
- Eastern Band of Cherokee
- White Mountain Apache

Contact tracing authority (n = 2)
- Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation
- Navajo Nation

Disease investigation authority (n = 1)
- Eastern Band of Cherokee

Health research (n = 4)
- Confederated Tribes of the Coos, Lower Umpqua, and Suislaw Indians
- Confederated Tribes of the Salish and Kootenai of the Flathead Reservation
- Ho-Chunk
- Navajo Nation

Note. There was a total of 10 tribal legal codes. Each code may contain more than 1 statute.
[a]In this category of codes, 1 code required only the reporting of blood alcohol content.

as would be the case for other health care providers.

Six codes (11%) contained disease-reporting provisions. Of these, 2 codes (4%) contained surveillance provisions, 2 contained authority to conduct contact tracing, and 1 explicitly noted disease-investigation authority. Four codes (7%) referenced health research issues and protections for human participants.

Intergovernmental Agreements

Our online review identified 8 formal agreements between tribes and other governments. Three main themes emerged from these intergovernmental agreements: emergency preparedness, data sharing, and collaboration around specific health issues.

Emergency preparedness. Five of the agreements focused on emergency preparedness, and 4 of these were mutual-aid agreements between tribes and county governments in Michigan, Montana, and Washington. These 4 agreements were designed to help jurisdictions understand their respective roles and responsibilities and to facilitate cooperative preparation, response, and recovery in the case of large-scale emergencies. The fifth agreement addressed emergency response for infectious disease outbreaks and other emergencies across the jurisdictions of the Tohono O'odham Nation, the state of Arizona, and the state of Sonora in Mexico. Topics addressed in these agreements included declaration and notification of emergencies, public information and alert networks, cross-jurisdictional coordination, cross-credentialing, epidemiological investigative authority, isolation and quarantine, data documentation, identification of vulnerable populations, mental health issues, training activities, functional exercises, ability to expand service capabilities, physical facilities, transportation, resource sharing, financial liability, contract pricing, and postemergency demobilization.

Data sharing. We found 1 data-sharing agreement, which addressed disease reporting and surveillance, privacy, confidentiality, data rights and ownership, data-sharing procedures, record keeping, and acceptable data uses. This agreement was established between the Gila River Indian Community and the Arizona Department of Health Services.

Collaboration around specific health issues. The third category of intergovernmental agreements pertained to the development of initiatives to address specified health issues such as domestic abuse prevention or physical activity. These documents defined partnerships among parties to the agreement, clarified the collaborative mission, and assigned roles or responsibilities to fulfill the agreement's goals.

Model Documents

We also reviewed 3 model documents designed to serve as templates for tribes that are drafting intergovernmental agreements, research codes, and health and safety codes. The American Indian Law Center has produced a Model Tribal Research Code[22] that contains guidance for establishing tribal regulation of research

activities and research-related checklists for Indian health boards. In addition, the Inter Tribal Council of Arizona has developed a Model Tribal Health and Safety Code that outlines critical features of a tribal code and presents a model format that tribes can use to develop their own codes. Revisions to the January 2005 draft of that document are currently under way (Z. Mahal, Inter Tribal Council of Arizona, oral communication, September 2008). Finally, the Model Tribal Head Start Health and Safety Code was developed jointly by IHS, the Head Start Bureau, and representatives from tribal Head Start programs to assist tribes in establishing and maintaining safe and healthy early-childhood environments.[23]

Subject-Matter Experts

We obtained input and guidance for this report from subject-matter experts affiliated with tribal governments, tribal organizations, tribal and Alaska Native health boards or health coalitions, tribal epidemiology centers, private legal practices working with tribes, and federal public health agencies. These experts represent a variety of relevant perspectives, and their observations are summarized in the box on this page.

DISCUSSION

Laws and other legal tools were instrumental in many of the public health accomplishments of the 20th century, such as control of infectious diseases, motor vehicle safety, fluoridation of drinking water, childhood vaccinations, and safer foods.[24,25] Conversely, the absence of such laws can have detrimental effects on public health. The repeal of mandatory motorcycle helmet laws, for example, has been associated with significant increases in deaths and serious injuries among motorcyclists, as well as substantial increases in acute care hospital charges.[26]

In Indian country, public health laws have improved the health and well-being of tribal community members. In 1988, for instance, the Navajo Nation enacted a safety belt law and a child-restraint law. Tribal leaders integrated public education on the safety belt law with strict enforcement of the law, resulting in an increase of safety belt use and a reduction in motor vehicle–related injuries.[27,28] The child-restraint law led specifically to significant decreases in motor vehicle–related injuries among Navajo children.[29] Since then, the use of safety belt laws in other tribal communities has increased over the years, but the National Highway Traffic Safety Administration found in 2004 that 39% of the tribal nations it surveyed still lacked such laws.[30]

Food safety is another arena in which legal tools have aided efforts to improve public health. The US Food and Drug Administration (FDA) provides model food codes and helps state, tribal, and local agencies implement national food regulatory policy

Summary of Subject–Matter Experts' Comments Regarding the Legal Foundations of American Indian/Alaska Public Health, by Topic: 2006

Structural characteristics

- Codification of public health statutes in tribal law is currently limited.
- Tribes are sometimes engaged in public health practice activities through memoranda of agreement or understanding that may or may not be formally based in tribal law.
- There is great variation in tribal public health infrastructures and in the balance between Indian Health Service (IHS)–provided and tribally provided public health services across Indian country.

Salience

- Public health issues common to federal, state, and local governments, such as the need for disease reporting across many diverse health care facilities, may not arise within individual tribes.
- Existing public health programs may be conducted through intertribal consortia rather than at the individual tribal level.
- IHS tends to focus more on clinical services than on public health services. Tribes may perpetuate this focus under the ''638'' process.[a]
- Emergency preparedness, as currently expressed by the federal government, is a relatively new concept for many tribes.
- Public health functions carried out under existing intergovernmental agreements may mask the need for formal codification of these agreements in law.

Challenges

- Process barriers are inherent to tribal governments, as they are to any bureaucracy or governmental agency.
- There is insufficient funding to support public health programs.
- There are limited public health training opportunities for tribal public health officials.
- Tribal governance and laws may not resemble federal or state laws, so models and templates for tribal laws may not be available.
- Cumbersome governmental clearance and approval processes may cause tribes to avoid the data collection necessary to many public health programs.

[a]The Indian Self-Determination and Education Assistance Act (Public Law 93-638).

uniformly.[31] The FDA also tracks the use of such codes by these agencies and has found that only 53 (16%) of the 343 tribes with food service operations had adopted a tribal food code.[32]

The ongoing delivery of essential public health services to any community depends upon a public health infrastructure comprising such key components as effective public health organizations, surveillance and information systems, a skilled workforce, research capability, and sustainable resources. Laws define the jurisdiction of public health officials responsible for this infrastructure and specify how they can exercise their authority,[33] so legal preparedness as defined herein should be an underlying element of public health infrastructure in any jurisdiction.

Public health infrastructures in tribal settings may differ from those seen in state and local jurisdictions (see the box on this page). Although tribal public health infrastructures support many beneficial public health activities, our findings suggest that these efforts could be enhanced by expanding the use of legal tools and establishing more tribal public health laws. Of the 70 tribal codes we initially located on the Internet, 14 (20%) had no clearly identifiable public health provisions. The public health–related statutes contained within the 56 remaining tribal codes were rarely well integrated or comprehensive, and there were few examples of laws specifically authorizing classic functions of communicable disease control such as quarantine, mandatory treatment, compulsory vaccination, or authority for disease reporting, investigation, or surveillance (see the box on the previous page). Among the broader public health provisions, those identified most frequently addressed traffic safety (61%), housing (59%), alcohol control (55%), and child abuse (57%). All other provisions addressing public health concerns (e.g., substance abuse, mental health, tobacco use, environmental health, public safety and injury prevention, sanitation, and domestic or elder abuse) were present in fewer than half of the codes we reviewed (Table 1).

Subject-matter experts consulted for this study reinforced the importance of public health legal preparedness to tribal governments and noted the challenges that tribal leaders may face in strengthening legal foundations for public health practice in their communities (see the box on the previous page). Most of the experts pointed out the limitations and variations extant in tribal legal codes, and they all agreed that tribal governments should give high priority to the establishment of tribal public health laws as a way to clarify jurisdictional issues and strengthen tribal public health authority. Their observations also indicate that public health legal preparedness is an emerging issue in Indian country that is gaining broader recognition from a wide array of tribal leaders and stakeholders. The subject-matter experts further indicated that our analysis was unique and that its results should be distributed to tribal leaders and other policymakers in Indian country. They also observed that broader input and more in-depth discussion would be needed to develop strategies to support and strengthen tribes' legal preparedness in the area of public health.

The range of intergovernmental agreements and model legal documents we identified suggests that tribes in different regions are beginning to use these legal tools to improve collaboration with neighboring governmental entities. Although these documents do not constitute legal codification per se, they are an expression of underlying tribal public health legal authority, and they demonstrate how tools like these can contribute to overall public health legal preparedness by providing a legal framework for cross-border collaboration.

Efforts to address the issues identified in this article are already taking place. The Web site of the CDC's Public Health Law Program includes tribal-specific links to legal tools useful to tribal governments (http://www2a.cdc.gov/

Examples of Public Health Infrastructure in American Indian/Alaska Native (AIAN) Tribal Jurisdictions: 2008–2009

Public health organizations
- Tribal health departments; related tribal governmental agencies
- Nonprofit tribal health organizations
- Tribal epidemiology centers[a]

Surveillance and information systems
- Voluntary reporting of notifiable diseases; participation in federal surveys
- Tribal-specific birth, death, and enrollment records
- Data-sharing agreements with states

Skilled workforce
- Public health education opportunities at tribal colleges and universities
- AIAN-focused health career scholarships and training programs
- Tribal systems for licensing and oversight of health professionals

Research capability
- Establishing and maintaining tribal institutional review boards
- Partnerships with academic institutions
- Tribal-specific research programs such as Native American Research Centers for Health[b]

Sustainable resources
- Federal and other grants, compacts and contracts with IHS, tribal tax revenues, tribal commercial enterprises

Note. Examples are based on observations by authors and subject-matter experts.
[a]For more information, see http://www.cdc.gov/omhd/Populations/AIAN/AIANEpiCntrs.htm.
[b]For more information, see http://www.ihs.gov/MedicalPrograms/Research/narch.cfm.

phlp/mutualaid). Issues germane to tribal public health legal preparedness are a critical component of the National Action Agenda for Public Health Preparedness (http://www.aslme.org/cdc).[34–36] Within that agenda, Bullard et al. identified a number of legal options for improving the coordination of tribal public health with other entities.[36]

Limitations

Our review of the status of tribal public health law was restricted to those tribal codes that were available online during an 11-week period in 2006. We were not able to determine whether these codes were current or complete. The full extent of a given tribe's existing public health laws may have included amendments, tribal council resolutions, tribal judicial decisions, or other additions or modifications that were not available to us. We did not review codes available online that required an access fee. Our subject-matter experts were drawn from diverse tribal, organizational, and geographic sectors, but they were not selected randomly or interviewed systematically and they cannot be considered representative of all stakeholders or subject-matter experts on tribal public health legal issues.

Conclusions

The primary purpose of this review was to provide an evidence base or informational foundation for understanding existing tribal public health law. We also intended for the results of our review to serve as a catalyst for more definitive action. The public health provisions in the tribal codes we reviewed tended not to be integrated or comprehensive; as a result, although many public health activities are under way in tribal communities, they are often taking place without the foundation of formal legal codification. Our findings suggest that tribal governments, like most state governments, would benefit from enhanced efforts to develop comprehensive public health codes and related legal tools.

The development of model documents such as tribal public health acts, intergovernmental agreements, legal guidelines for public health practice, technical assistance materials, and training modules—all tailored to tribal settings—may be of value to tribal leaders as they move toward strengthening public health legal preparedness. The development of these tools and approaches will likely require collaborative efforts including tribal governments, state and local governments, federal health agencies, academic institutions, private-sector legal firms, and philanthropic organizations. Each of these entities can contribute resources and expertise to help establish public health legal foundations in Indian country. Such legal foundations are critical to effective public health emergency response and fundamental to providing the ongoing benefits that public health functions and essential services bring to tribal communities. ■

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This article was accepted October 4, 2008.

Note. *The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.*

Contributors

R.T. Bryan originated the project and led all aspects of its implementation. R.M. Schaefer conducted the bulk of the tribal code analyses and produced the first draft of the article. L. DeBruyn assisted with project design and synthesis of analyses. D.D. Stier supervised R.M. Schaefer and assisted with code reviews and synthesis of the analyses. All authors helped to conceptualize ideas, interpret findings, and review and rewrite drafts of the article.

Acknowledgments

This project was first conceptualized and planned during meetings of the CDC Tribal Public Health Law Work Group, and we gratefully acknowledge the contributions of the Work Group members: Barbara Altman, Jeanne Bertolli, Valerie Davidson, Deborah Erickson, Sherry Everett Jones, Joe Finkbonner, Hillary Frierson Keeley, Jennifer Giroux, Richard Goodman, John Mosely Hayes, Mechelle Johnson Webb, Michael Landen, Jean Francois Luc, Tony Moulton, J.T. Petherick, Francine Romero, and Teresa Wall. We also acknowledge the contributions of subject-matter experts and the helpful comments and article critique provided by Richard Goodman, MD, JD, MPH.

Human Participant Protection

No protocol approval was needed for this study.

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